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ABSTRACT

Use of the Helping Relationship Inventory (HRI) to assess the impact of an introductory medical interviewing course on beginning medical students' preference for interview response modes was studied at the University of Minnesota. The HRI, a brief paper-and-pencil instrument, was administered as a pre-test and post-test for five consecutive years (1975-79). Attention was directed to the impact of the medical interviewing course on students' preferences for the following alternative responses to patients' written statements: "understanding," "probing," interpretive," "supportive," and "evaluative." In 1978 and 1979, the HRI was also administered several months before the course to assess the persistence of changes. A course description and information on the evaluation instrument and data collection methodology are presented along with pre-test, post-test, and followup test results for each of five consecutive years. Significant increases in students' preferences were found for understanding responses and decreases in preferences for evaluative responses. Changes were in the desired direction, since rapport is generally enhanced by conveying understanding and refraining from premature evaluation. It was also found that tutor experience in teaching the course was not significantly related to variations in outcome results; students with new tutors did not have significantly different response preferences than students of more experienced tutors. The consistent pattern of results for five years supports the construct validity of the HRI. Effects on response preferences of some instructor characteristics are analyzed, and implications for health professional education and research are discussed. (SW)

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Evaluation of a Medical Interviewing Course: The Helping Relationship Inventory

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A relatively brief, easily-administered paper and pencil instrument--the Helping Relationship Inventory (HRI)--has been used to assess the impact of an introductory medical interviewing course on beginning medical students' preferences for interview response modes categorized as: Understanding, Probing, Interpretive, Supportive, and Evaluative. The purposes of this paper are to: (1) discuss the context in which the instrument has been used; (2) present and analyze the results of administering the HRI as a pre and post-test to five consecutive classes of first year students; and (3) discuss the implications of the results for health professions education and evaluation of medical interviewing.

PERSPECTIVES

Effective communication with patients in the medical interview and other therapeutic interactions is crucial for obtaining accurate diagnostic information, securing cooperation in treatment, and effecting successful therapeutic outcomes (Bernstein, Bernstein and Dana, 1973; Blum, 1960; Bogdanoff, et al.,

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1965; Enelow and Wexler, 1966; Hulka, et al., 1976; Kimball, 1969; Korsch, 1968; Gozzi and Francis, 1968; and Rogers, 1958). The complex nature of interpersonal communication has frequently led to the viewpoint that the communication aspects of interviewing and therapeutic interaction are in the realm of personal, idiosyncratic skills (see discussion in Bernstein, Bernstein and Dana, 1973). Recently, however, scholars and practitioners in the helping professions have attempted to formulate and systematize principles and techniques for effective communication (e.g., Bernstein, Bernstein and Dana, 1973; Enelow and Wexler; 1966; Porter, 1950; and Rogers, 1958). These investigators demonstrate various persuasions concerning the nature of helping relationships. However, they generally agree that effective communication in helping relationships is enhanced if the interviewer conveys empathetic understanding of the patient's meanings and feelings and refrains from making premature evaluative responses. Thus, the patient is likely to feel free to tell his/her story and reveal himself/herself, an important aim of interviewing and therapeutic interaction. This view of interviewing is associated with what has been labeled as a 'non-directive' approach to interviewing, although as Carroll and Monroe (1980) note, "...there is considerable disagreement as to what specific skills constitute this overall approach" (p. 39).

Within the past five years, most medical schools have included in their curricula some formal instruction in the communication aspects of medical interviewing (Kahn, Cohen and Jason, 1979). This proliferation of new courses most likely reflects both increased recognition of the importance of communication skills for physicians, as well as increased codification of principles and techniques associated with effective communication. Most of these courses focus on principles and techniques for nondirective interviewing operationalized in statements of discrete, observable skills (such as using open-ended or non-

leading questions) specified on rating scales or checklists (Carroll and Monroe, 1980). The most prevalent instructional strategies used in these courses are various combinations of: lecture-discussions; programed film demonstrations with feedback for student responses at nodal interview points; live demonstration interviews; and practice interviews with real or simulated patients followed by videotape or direct feedback (Carroll and Monroe, 1980).

Typically, these courses have been evaluated using instructors' subjective ratings of students' performance and student opinion surveys (Carroll and Monroe, 1980). Sophisticated methods are available for evaluation of medical interviewing skills, such as observer rating of live or videotaped interviews with real or simulated patients (Barbee and Chosy, 1967; Helfer, Black and Helfer, 1975; Hess, 1969; Hinz, 1966; Jarrett, et al., 1972; and Stillman, Sabers and Redfield, 1977). Typically, these evaluation methods are used for purposes of course evaluation research, with limited numbers of students. However, they tend to be unsuitable for routine course evaluation with large numbers of students due to their cost and complicated logistical requirements. The Helping Relationship Inventory (HRI), to be described in this paper, offers by contrast an easily administered means for assessing a limited, but important, outcome of a medical interviewing course.

During the first quarter of the medical school curriculum at the University of Minnesota, all students are required to take a course that focuses on the communication aspects of medical interviewing. Beginning in 1975, for each of five consecutive years, the HRI, a brief paper-and-pencil instrument, has been administered as a pre-test and post-test to assess the impact of the course on an important outcome: students' preferences for alternative responses to written patients' statements, categorized as Understanding (U), Probing (P), Interpretive (I), Supportive (S), and Evaluative (E). In 1978 and 1979, the

HRI was also administered several months subsequent to the course to assess the persistence of changes. This paper describes the course, the evaluation instrument, and the method of data collection; it presents pre-test, post-test, and follow-up test results for each of five consecutive years; and it suggests implications of this evaluation study for health professions education and evaluation of medical interviewing.

COURSE DESCRIPTION

The course has been taught during the first quarter of the medical school curriculum, primarily in small group tutorials with approximately eight students per group, to the entire class (n=240). During 1975 and 1976, the course included three large group lecture-demonstration sessions and 10 weekly two-hour tutorial sessions which focused primarily on communication skills. During 1977, 1978, and 1979, the course included six large group lecture-demonstration sessions and 10 weekly two-hour tutorial sessions which incorporated a combined emphasis on communication and history-taking skills. Students and their tutors met and interviewed patients at several different hospital settings, primarily the University hospital, two county hospitals, and a Veterans Administration hospital. These sessions were the first segment of a year-long clinical medicine course in which students learned to take medical histories and do physical examinations.

The major learning goals of the first segment have been for students to utilize interview techniques for establishing patient trust and rapport and for encouraging patients to accurately tell their stories. These techniques have been codified and exemplified in a course syllabus, selected readings, the lecture-demonstrations, tutor live demonstrations, and interview rating forms. During the small group sessions, students in pairs (with one student interviewing and the other observing) interviewed patients, usually in hospital

wards. Both interviewers and observers filled out rating instruments that identified desirable interviewing behaviors as a basis for discussion and assessment of the student's interview. Subsequently, tutors led small group discussions that focused on students' identification of their own, others' and patients' feelings, opinions, and values as well as the process and content of the interviews. Also, interviewers wrote formal reports of their interviews to be reviewed by their tutors.

Thirty tutors are required to teach this course. The tutors have included psychiatrists, family practitioners, psychologists, psychiatric nurses (M.A. level), and social workers. Most tutors have taught the course previously, but each year a few new tutors have been added. Some primary tutors have been assisted by co-tutors so as to increase opportunities for student feedback. Each year, all tutors have been invited to a pre-course orientation session focusing on course goals and teaching strategies.

HELPING RELATIONSHIP INVENTORY AND DATA COLLECTION

The HRI consists of selected items from an instrument adapted by Jones (1967) from an inventory originally developed by Porter (1950) to train and evaluate counselors. In each of ten items, students are presented with brief patient statements, each followed by five alternative responses categorized (without students' knowledge) as Understanding (U), Probing (P), Interpretive (I), Supportive (S), and Evaluative (E). (Hereafter, the response categories will be referred to as U, P, I, S, and E.) They are asked to rank the alternative response-options in the order of their preference, assigning 1 to the response viewed as "most apt", 5 to the response viewed as "least apt", and so on.[1] Subscale scores are obtained by summing ranks for each type of response

[1] Instructions for the entire HRI and a sample item are included in Figure 1.

mode across the ten items, yielding subscores that indicate preference tendencies for U, P, I, S, and E responses. Thus, for each subscale, the lowest possible score is 10 and the highest 50, with a low subscale score indicating a greater preference for a response mode than a high score.

The response modes, as defined by Porter (1950), are consistent with standard interpretations. Understanding responses indicate attempts to accurately reflect the patient's meanings and feelings. Probing responses aim at gathering further information or provoking discussion along certain lines. Interpretive responses indicate attempts to teach the patient, to impart meaning. Supportive responses aim at reassuring the patient. Evaluative responses indicate judgments of the relative goodness or appropriateness of the patient's statements and feelings. The alternative response-options were checked for congruence with these definitions through assignment to the response-mode categories by independent judges; only those response-options conforming to intended response modes, as assessed by agreement among three judges, were included in the inventory (Jones, 1967).

Previous studies have demonstrated high reliability for the subscales (Hopke, 1955; and Jones, 1967) and statistically significant relationships between students' responses on the HRI and their actual interview responses (Hopke, 1955). Several studies demonstrated that members of the helping professions tend to have the greatest preference for U responses and the lowest preference for E responses (Hopke, 1955; Jones, 1967; Munger and Johnson, 1960; Munger, Myers and Brown, 1963; and Remos and Zuwaylif, 1963). The instrument thus appears particularly appropriate for assessing changes in interviewing response preferences attributable to a course in the communication aspects of medical interviewing.

Beginning in 1975, for each of five consecutive years, the HRI has been

administered as a pre-test during the first week of the course and as a post-test during the tenth and final week of the course, with the exception of 1979 when the post-test was administered (due to logistical difficulties) two months subsequent to the interviewing segment of the course. In 1978, a follow-up test was administered two months subsequent to the interviewing sessions to assess the persistence of changes; and the results of the 1979 post-test can be interpreted in the same light.

RESULTS

Results of administering the HRI as a pre and post-test for five consecutive years (as well as a post-post-test for one of these years) are shown in Tables 1 and 2. Analysis of pre/post-test data for each of the five consecutive years shows strikingly similar group means for each sub-scale on the pre-tests and post-tests and strikingly similar patterns of pre/post-test changes. The greatest changes were in students' preferences for U and E responses (except for 1978 and 1979). There were statistically significant increases in mean preferences for U responses (correlated means t-tests, $p<.001$) and statistically significant decreases in mean preferences for E responses (for 1975, 1976, and 1979, $p<.001$; for 1977, $p<.05$), except for 1978, although for 1978 there was a statistically significant decrease in mean preference for E responses from pre-test to post-post-test ($p<.001$). Students also showed decreased preferences for I responses which reached statistical significance for four of the five years (for 1976, 1979, and 1980, $p<.001$; for 1975, $p<.05$) and for S responses which also reached statistical significance for four of the five years (for 1975, 1976, and 1978, $p<.001$; for 1977, $p<.05$). The strongest preferences were shown for P responses on both the pre and post-tests; there were statistically significant increases in preferences for P responses for three of the five years ($p<.001$). The pattern of these changes is graphi-

cally displayed in Figure 2, using pre/post-test results from 1976 as an example. These changes were not only maintained in the 1978 post-post-test (Table 2 and Figure 3), but in the case of U and E responses there were in fact continued changes in the same directions, with a statistically significant increase in mean preference for U responses from post to post-post-test ($p<.001$) and a decrease in mean preference for E responses from post to post-post-tests ($p<.05$). The data were analyzed with parametric statistics since there was no reason to suspect gross violation of the standard assumptions.

The changes in pre/post-test and follow-up subscale scores were also analyzed (analysis of covariance) in relation to several potentially important variables: student sex; tutor discipline (family practice, psychiatry, and other health care professionals); tutor experience ("taught the course previously" or "did not teach the course previously"); co-tutor ("yes" or "no"); and hospital setting (University, County, Veterans Administration, other). No significant differences were found in any of the subscale scores in relation to any of these variables, except the variable of student sex. There were consistent differences in some subscale scores on the post-tests in relation to student sex, which at times reached statistical significance. Females demonstrated greater mean preferences for U responses than males (for 1979, $p<.001$; for 1977 and 1978, $p<.05$) and also significantly greater mean preferences for P responses than males (for 1978, $p<.001$; for 1979, $p<.05$). By contrast, males demonstrated significantly greater mean preferences for E responses than females (for 1977, 1978, and 1979, $p<.001$).

DISCUSSION

The most striking results of this study are the differences in interview response preferences that appear to be attributable to a relatively brief (≈30 hours) course in the communication aspects of medical interviewing. Clearly,

each of the response modes can be useful depending on the interview context and purpose. This course, however, emphasized techniques for the development of rapport and for encouraging patients to tell their stories in the context of an initial interview. These purposes are best achieved if the interviewer conveys understanding and refrains from premature evaluative responses. Thus, the major changes are in the desired direction. As noted, students demonstrated the greatest preferences for P responses both on pre and post-tests, a finding that is perhaps appropriate given two major purposes of the medical interview, symptom pursuit and medical diagnosis. These findings, of significant changes in desired directions, are not surprising. In a review of 37 empirical studies of the effects of formal instruction in communication skills, Carroll and Monroe (1980) conclude, "...research has consistently shown significant effects of formal instruction" (p. 24). However, none of these studies report replications, a situation due no doubt, in part, to the cost and complex logistical requirements associated with the sophisticated assessment strategies used in these studies. The availability of the HRI makes it possible to replicate the effects it assesses, which are limited but important outcomes of a medical interviewing course.

Analysis of pre/post-test changes in relation to other potentially important variables permits us to address some issues in teaching communication skills. The question "Who can/should teaching medical interviewing?" is an important one for health professions educators. Instruction in medical interviewing is particularly time-consuming, since individualized feedback to students on their practice interviews has been shown to be a crucial variable in desired outcomes (Carroll and Monroe, 1980). Therefore, it is necessary to extend the faculty and other resources available for teaching communication skills. Other investigators have reported the effective use of students (Flax

and Garrard, 1974; and Barnes, et al., 1978) and simulated patients (Helfer, et al., 1975; and Stillman, et al., 1977) for teaching communication skills. At least in terms of the outcome variables assessed in this study, tutor discipline (family practice, psychiatry, psychology, social work, and psychiatric nursing) makes no difference. This finding supports other results which suggest that a variety of individuals can effectively teach communication skills.

It is interesting and perhaps surprising that the subscale score changes did not vary in relation to the availability of co-tutors. Since one major purpose for assigning co-tutors to groups has been to provide additional feedback, we would have expected that this additional feedback would have been reflected in HRI outcomes. However, in addition to primary and co-tutor feedback, there is considerable feedback given to students by their peers in the small group discussions, based on observations of peer interviews. This extensive student-peer feedback may help to explain why the addition of co-tutors to some groups was not reflected in measurable differences on HRI outcomes.

It is interesting that tutor experience in teaching the course is not significantly related to variations in outcome results; students with new tutors did not have significantly different response preferences than students of more experienced tutors. The authors attribute this result to factors associated with course organization: orientation of tutors to goals and teaching strategies; provision of a syllabus for students and tutors, with descriptions of goals and teaching strategies; rating forms with criteria for assessment; readings that codify principles and techniques; and lecture-demonstrations presented to the entire class. These provisions for the implementation of core learning goals and experiences through various aspects of course structure and organization may also help to account for the finding that the subscale scores did not vary in relation to hospital setting. This view is supported by a recent study

conducted by Smith and his colleagues at the University of Washington, Seattle, which demonstrated that subscale scores on the HRI did not vary in relation to the program site at which their first year medical interviewing course was taught (1980).

It is noteworthy that the subscale scores did vary in relation to student sex in that females demonstrated significantly greater mean preferences for U responses than males for three of the five years, while males demonstrated significantly greater mean preferences for E responses for three of the five years. These results are intriguing and merit further investigation.

Several aspects of this study are particularly noteworthy. First, most evaluation studies report one year or, at most, two years of data and proclaim the programs a success (Lennox, 1980). The availability of the HRI made it logistically feasible to conduct four replication studies. Consequently, this study reports five consecutive years of strikingly similar pre and post-test data as well as patterns of change and can thus support claims of course effectiveness with somewhat greater certainty.

Second, the consistent patterns of results for five consecutive years also contribute to supporting the construct validity of the HRI. It should be noted that further support for the instrument's construct validity is provided by Smith and his colleagues' use of the HRI to assess the effectiveness of their first year medical interviewing course taught at different sites of the University of Washington's WAMI program. Surprisingly, their actual mean pre and post-test scores and patterns of change across sites were quite similar to those obtained in the original and the replication studies at Minnesota.

Third, with few exceptions (Stillman, et al., 1977) evaluations of medical interviewing courses are done immediately subsequent to instruction, but do not report follow-up data (Carroll and Monroe, 1980). This study reports outcomes

which appear attributable to the course that persist several months subsequent to instruction when students have begun to focus on physical examination skills. Clearly, studies are needed to assess the effects of interviewing courses over even longer periods of time. The availability of the HRI makes it logistically feasible to conduct extensive follow-up evaluations of the outcomes it assesses.

This study has several important limitations which suggest the need for future research. The first limitation relates to the question of what is measured by the HRI. This instrument presents written simulations and elicits self-report responses. At the least, it assesses students' ability to identify desirable responses, but most likely, given that the HRI was not used for grading and students were not explicitly taught response category labels, it also assesses attitudes, i.e. actual response preferences. Although other investigators have demonstrated a relationship between HRI response preferences and actual interview responses (Hopke, 1955), further research is needed to validate this relationship, since the real goal of instruction is clearly to improve actual interviewing skills. Even if such relationships were found, it is clear that the HRI is designed to assess only one reflection of interviewing skills. It is not intended as a measure of actual interviewing competence and other methods will remain essential for evaluating such skills. These methods include observer ratings of live or videotaped interviews with real or simulated patients. In addition, assessments of interviewing skills that focus on patient satisfaction and care outcomes are needed, since these outcomes are the ultimate goals of instruction in medical interviewing. Furthermore, research is needed to identify which specific skills or qualities are consistently related to patient outcomes. As Carroll and Monroe (1980) note, "While virtually all programs on clinical interviewing stress nondirective interview techniques in general, there is considerable disagreement as to what specific

skills constitute this overall approach" (p. 39). Clearly, it would be desirable to identify these specific skills, with actual patient outcomes as a criterion.

Another limitation of this study was the lack of control groups. Like most other studies in this area, this study utilized a pre-experimental design, susceptible to many confounding factors (Campbell and Stanley, 1963). In the context of a structured medical school curriculum, it has not been viewed as desirable or possible to deny instruction in communication skills to a selected group of students. Clearly, however, randomized control group studies would contribute to a clearer understanding of the issues addressed in this study.

A further limitation of this study is that it was not designed to assess which specific aspects of the course contributed to the outcomes, but rather to assess the effects of this course as a whole. Like most of the other formal courses, this course incorporates a combination of instructional strategies (Carroll and Monroe, 1980). Thus, this study does not contribute to assessment of the effectiveness of any particular instructional strategy. Moreover, it does not provide guidance for course development based on assessment of specific aspects of the course which related to outcome measures.

Despite these limitations, the HRI is valuable as a brief, easily administered instrument that assesses one particularly important outcome of a medical interviewing course. Five years of successive pre/post-test course outcome data that show similar patterns of statistically significant changes in desired directions suggest both the effectiveness of the course and the construct validity of the instrument.

TABLE 1

ANALYSIS OF FIRST YEAR STUDENTS' PRE-TEST AND POST-TEST MEAN SCORES ON THE HELPING RELATIONSHIP INVENTORY FOR FOUR YEARS+

TIMES OF PRE/POST-TEST ADMINISTRATION	RESPONSE MODES														
	UNDERSTANDING			PROBING			INTERPRETIVE			SUPPORTIVE			EVALUATIVE		
	PRE MEAN (s.d.)	POST MEAN (s.d.)	T VALUE	PRE MEAN (s.d.)	POST MEAN (s.d.)	T VALUE	PRE MEAN (s.d.)	POST MEAN (s.d.)	T VALUE	PRE MEAN (s.d.)	POST MEAN (s.d.)	T VALUE	PRE MEAN (s.d.)	POST MEAN (s.d.)	T VALUE
1975-76 (September 1975 and November 1975) (n=228)	30.8 (8.3)	23.5 (9.0)	14.72**	23.7 (4.9)	22.4 (4.9)	3.83**	35.7 (4.4)	36.3 (4.7)	1.97*	27.9 (5.5)	31.4 (6.1)	9.70**	31.1 (5.5)	35.8 (5.5)	13.42**
1976-77 (September 1976 and November 1976) (n=228)	30.8 (8.0)	24.5 (8.5)	12.68**	23.0 (4.6)	22.6 (5.1)	1.04	34.9 (4.9)	35.8 (5.7)	2.76**	28.4 (5.6)	30.7 (6.0)	6.21**	31.3 (6.2)	34.9 (5.9)	10.00**
1977-78 (October 1977 and January 1978) (n=158)	29.0 (8.6)	23.7 (9.4)	5.55**	21.5 (4.9)	22.2 (5.0)	1.43	35.6 (4.8)	35.9 (5.5)	0.69	29.6 (5.6)	31.0 (6.9)	2.10*	33.7 (5.3)	35.2 (6.9)	2.31*
1979-80 (October 1979 and March 1980) (n=242)	29.9 (5.9)	26.0 (6.0)	7.26**	24.7 (3.9)	23.6 (4.1)	3.21**	33.1 (5.1)	35.4 (4.5)	5.3**	29.9 (4.2)	30.5 (4.3)	1.42	30.7 (5.0)	32.3 (4.6)	3.77**

* $\rho < .05$ (matched pairs t-tests)
** $\rho < .001$ (matched pairs t-tests)

\+ Data are included only for students who took both pre and post-tests.

Note: Lower scores indicate greater preferences for response modes than higher scores.

TABLE 2

ANALYSIS OF FIRST YEAR STUDENTS' PRE-TEST, POST-TEST AND POST-POST-TEST MEAN SCORES ON THE HELPING RELATIONSHIP INVENTORY FOR 1978-79 [1, 2, 3]

RESPONSE MODES	PRE-TEST MEAN	PRE-TEST S.D.	POST-TEST MEAN	POST-TEST S.D.	POST-POST TEST MEAN	POST-POST TEST S.D.	T VALUES	
UNDERSTANDING	29.8	6.0	26.2	6.6	24.7	6.1	Pre/Post	8.57**
							Pre/Post-Post	13.00**
							Post/Post-Post	3.81**
PROBING	24.8	3.4	23.3	4.2	23.6	4.1	Pre/Post	5.12**
							Pre/Post-Post	4.28**
							Post/Post-Post	.96
INTERPRETIVE	33.9	4.8	35.5	6.0	35.8	5.5	Pre/Post	3.77**
							Pre/Post-Post	5.01**
							Post/Post-Post	.92
SUPPORTIVE	29.5	3.7	30.8	5.2	31.2	4.9	Pre/Post	3.63**
							Pre/Post-Post	4.52**
							Post/Post-Post	.95
EVALUATIVE	31.6	4.2	31.8	5.2	32.5	5.2	Pre/Post	.43
							Pre/Post-Post	2.35**
							Post/Post-Post	1.88*

** $p < .001$, matched pairs t-tests
* $p < .05$, matched pairs t-tests

Notes:
1. n=230
2. Lower scores indicate greater preferences for response modes than higher scores.
3. Data are included only for students who took both pre-tests, post-tests, and post-post-tests.

FIGURE 1

INSTRUCTIONS FOR ENTIRE HELPING RELATIONSHIP INVENTORY
AND SAMPLE ITEM

HELPING RELATIONSHIP INVENTORY INSTRUCTIONS

This is not a test in the sense that your answers can be right or wrong. It is a survey of your feelings concerning the relationship between two persons when one is attempting to help the other. Imagine yourself as a person to whom another person has come for personal assistance. Each of the items represents possible interchanges between you and your "client", who seeks your help. The "client" begins the conversation by talking about an aspect of the situation he faces. No further information is available on the case. You will not know at what point in the conversation the interchange takes place. In short, you are presented with an isolated statement. This is followed by five possible responses that you may make.
Arrange these responses in the order of your preference, using the following code:

1	for the response you would be most apt to favor
2	for the response next most desirable to you
3	for the next
4	for the next, and
5	for the response that least represents your preference.

The wording used may not strike you as being the best, but disregard this factor as long as the response is the same type you would favor. You may think of responses which would be more preferable from your point of view. It is necessary, however, that you make your selection from the alternatives presented and that you arrange all five in the order of their desirability.

(continued)

FIGURE 1 (continued)

SAMPLE ITEM

Man, age 60

"I've got it all figured out. There's nothing for me to live for any more. My wife's dead. My kids don't need me. I'm too old to get a job. Just the fifth wheel on a wagon. And I'm tired of it all. I'm going to end it all, put a bullet through my brain. And rest in peace."

_____ a. You feel there's nothing left in life for you.

_____ b. When things add up for a person like they've added up for you, it really does make it tough to face. And sometimes there doesn't seem to be a way out. Yet -- I think that we may be able to find a way out.

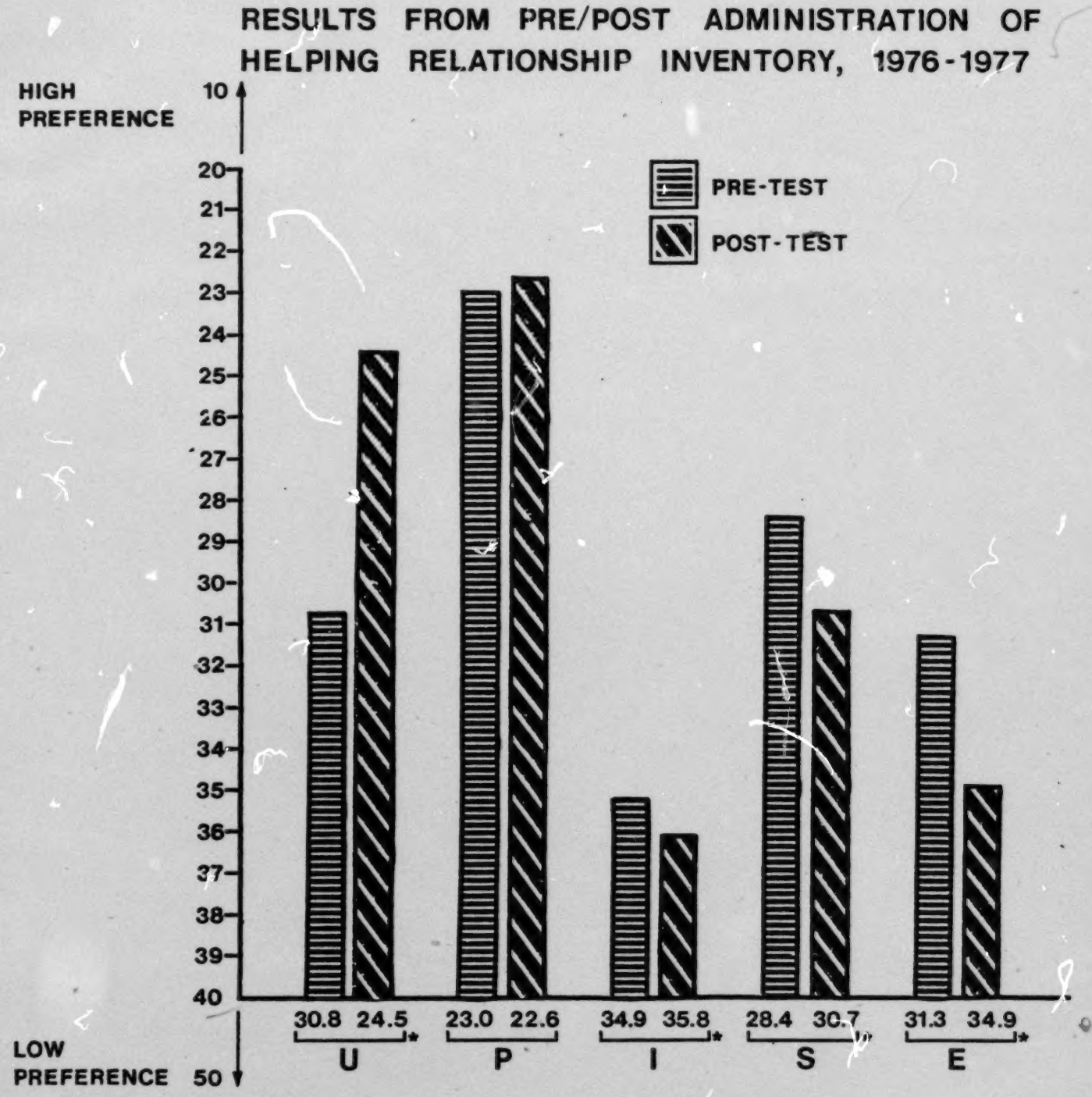
_____ c. How long have you felt this way, may I ask?

_____ d. Escaping is one way, all right. But have you thought of what it would mean to your children to have you commit suicide?

_____ e. It seems to me that you are looking for a way to escape an otherwise intolerable situation.

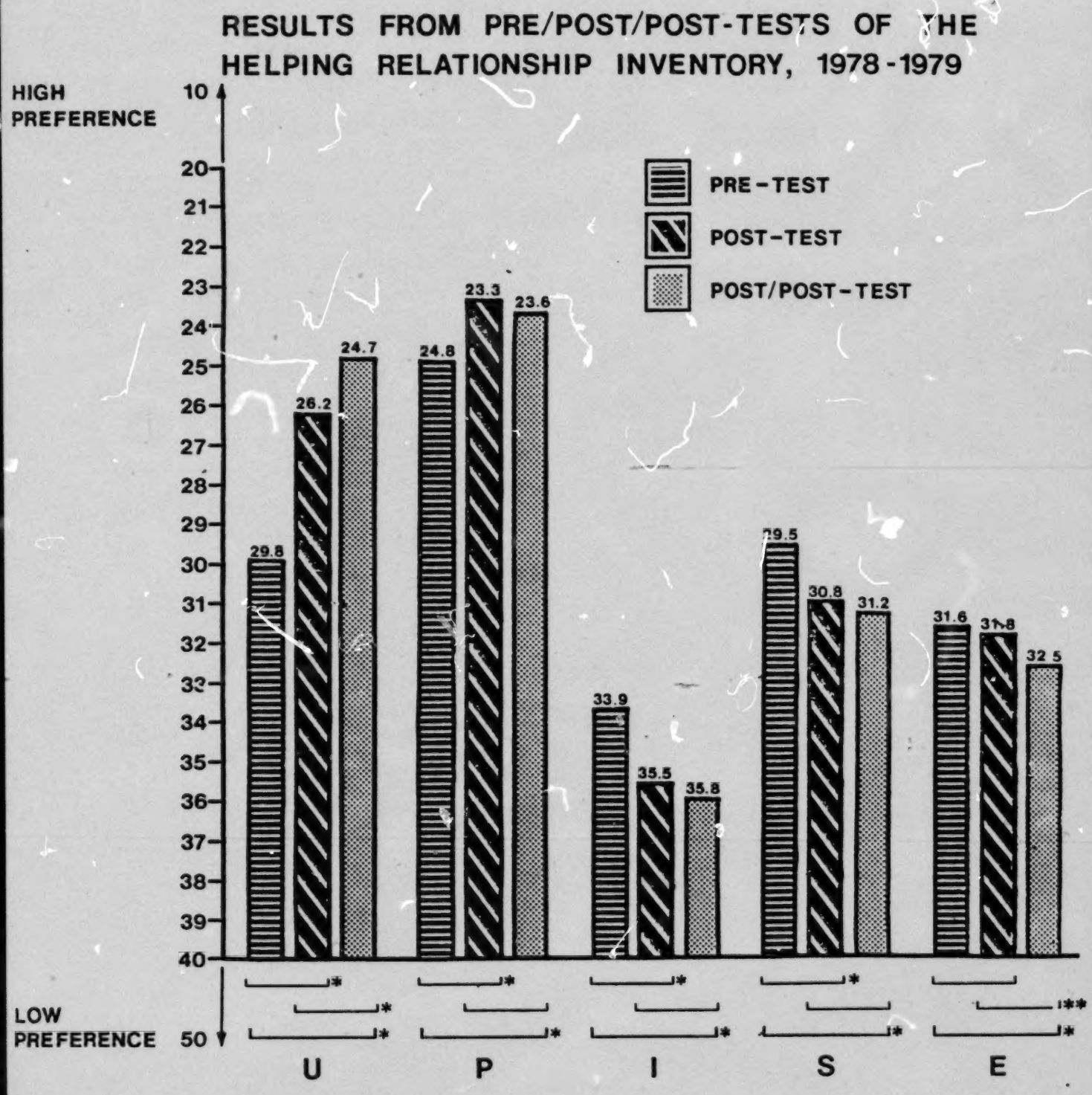
KEY:
a. UNDERSTANDING
b. SUPPORTIVE
c. PROBING
d. EVALUATIVE
e. INTERPRETIVE

FIGURE 2



* p < .001, MATCHED-PAIRS T-TESTS
n = 228

FIGURE 3


RESULTS FROM PRE/POST/POST-TESTS OF THE HELPING RELATIONSHIP INVENTORY, 1978-1979
HIGH PREFERENCE
LOW PREFERENCE
10
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
50
PRE-TEST
POST-TEST
POST/POST-TEST
29.8
26.2
24.7
24.8
23.3
23.6
33.9
35.5
35.8
29.5
30.8
31.2
31.6
31.8
32.5
U
P
I
S
E
* p < .001, MATCHED-PAIRS T-TESTS
** p < .05, MATCHED-PAIRS T-TESTS
n = 230

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